WISCONSIN

DEPARTMENT OF WORKFORCE DEVELOPMENT
Division of Workforce Solutions
Bureau of Workforce Programs

TO: **Economic Support Supervisors**
Economic Support Lead Workers
Training Staff
Child Care Coordinators
W-2 Agencies

FROM: Stephen M. Dow
Employment Support Unit
Workforce Policy Development Section

BWP OPERATIONS MEMO

No.: 01-84

File: 2792

Date: 12/272001

Non W-2 [X] W-2 [ ] CC [ ]

PRIORITY: High

SUBJECT: **WISCONSIN WELL WOMAN MEDICAID**

EFFECTIVE DATE: January 1, 2002

PURPOSE

This memo introduces the Wisconsin Well Woman Medicaid (MA) program to Economic Support (ES) workers and outlines the policy and process of this new program.

BACKGROUND

Under current law, DHFS receives federal funding to conduct a breast and cervical cancer early detection program, the Wisconsin Well Woman Program (WWWP), which is administered by the State Division of Public Health. This program provides eligible women with various health screenings (including breast and cervical cancer screening), referrals, education, and outreach.

The federal Breast and Cervical Cancer Prevention and Treatment Act of 2000 amended Title XIX of the Social Security Act to provide MA eligibility and full MA benefits to uninsured women under age 65 who are screened through the WWW screening **and** are in need of treatment for breast cancer or cervical cancer. The federal Act had an effective date of October 1, 2000.

Wisconsin adopted this MA program effective January 1, 2002.

About 50 women are expected to be determined eligible for Wisconsin Well Woman MA in the first year.

POLICY

To be eligible for Wisconsin Well Woman MA a woman must meet **all** of the criteria listed below:

1. Be 64 years of age or less.

2. Be a resident of Wisconsin.

3. Be a citizen or qualifying alien.

4. Provide an SSN or be willing to apply for one.

5. Not eligible for private or public health care coverage. (This includes: group health plans, health insurance, Medicare Parts A or B, MA, veterans benefits/CHAMPUS, Indian Health Service, HIRSP, federal employee health plans, Peace Corps health plans, or other public health plans.)

   Note that the following health care benefits do not disqualify a woman from Wisconsin Well Woman MA:

   a. Types of health benefits not counted as health insurance when determining eligibility for Wisconsin Well Woman MA:

      - Coverage only for accident, or disability income insurance, or any combination thereof.
      - Liability insurance, including general liability insurance and automobile liability insurance.
      - Workers' compensation or similar insurance.
      - Automobile medical payment insurance.
      - Credit-only insurance.
      - Coverage for on-site medical clinics.
      - Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

   b. Benefits not considered health insurance if offered separately:

      - Limited scope dental or vision benefits.
      - Benefits for long-term care, nursing home care, home health care, community based care, or any combination thereof.
      - Such other similar, limited benefits.

   c. Benefits not considered health insurance if offered as independent, uncoordinated benefits:

      - Coverage only for specified disease or illness.
      - Hospital indemnity or other fixed indemnity insurance.

   d. Benefits not considered health insurance if offered as separate insurance policy:

      - Medicare supplemental health insurance, coverage supplemental to the coverage provided under Chapter 55 of Title 10, and similar supplemental coverage provided

to coverage under a group health plan. However, Medicare Parts A or B disqualify a woman from eligibility for Wisconsin Well Woman MA.

6. Have been screened for breast or cervical cancer by the Wisconsin Well Woman Program (WWWP).

7. Have a diagnosis of breast or cervical cancer, as identified by the screener.

8. Require treatment for the breast or cervical cancer, as identified by the screener.

9. Not be eligible for any other subprogram of MA, including BadgerCare.

PRESUMPTIVE ELIGIBILITY FOR WISCONSIN WELL WOMAN MEDICAID

Presumptive eligibility is available for women who have been screened by a MA provider. If the provider is not a MA provider, authorized at EDS, the woman will not be determined presumptively eligible for Wisconsin Well Woman MA.

From the date of diagnosis through the last day of the following calendar month, she may receive services by presenting the completed Wisconsin Well Woman Program (WWWP) Enrollment Form (DPH 4818) and Wisconsin Well Woman MA Determination Form (HCF 10075) to any MA provider. The screener will have indicated in the comments section of the Wisconsin Well Woman MA Determination Form (HCF 10075) the end date of the woman's presumptive eligibility. Once the Local WWWP Coordinator has faxed the MA Determination Form (HCF 10075) to EDS, the woman will be issued a Forward card. ES cannot deny or close the presumptive eligibility segment before the end date established by the Local WWWP Coordinator. There is no limitation to the number of presumptive eligibility segments that a woman can have for Wisconsin Well Woman MA.

If the woman wants to continue to receive Wisconsin Well Woman MA, she must apply at the local county/tribal social or human services agency. If she does not apply, her MA benefit will end at the end of the month following the month of diagnosis.

The woman may apply for Wisconsin Well Woman MA at any time after her diagnosis has been made through a WWWP screening. ES can only backdate her eligibility for a period of up to 3 months prior to the application date or the diagnosis date; whichever is later.

WWWP SCREENER PROCESS

Most of the data gathering, review, and verification is done by the WWWP Local Coordinating Agencies (see the attached Local Coordinating Agency list). The Local WWWP Coordinators will complete and sign the Wisconsin Well Woman Program (WWWP) Enrollment Form (DPH 4818) with the assistance of the woman before the woman is screened.

The WWWP screeners and/or providers will:

1. Complete and sign the Wisconsin MA Determination Form (HCF 10075) with the woman's help.

2. Explain that the duration of her presumptive eligibility for Wisconsin Well Woman MA will end at the end of the following calendar month.

3. Identify in the comment section of the Wisconsin MA Determination Form (HCF 10075) the beginning and end date of the presumptive eligibility period.

4. Give the client a copy of the signed Wisconsin MA Determination Form (HCF 10075).

5. Send/Give the signed Wisconsin MA Determination Form (HCF 10075) to the Local WWWP Coordinator.

The Local WWWP Coordinator will fax a copy of the completed application form to EDS, at (608) 221-8815. This must occur within 5 days of the diagnosis date.

ELIGIBILITY PROCESS FOR WISCONSIN WELL WOMAN MEDICAID

Wisconsin Well Woman MA is a manual program; these women should not be entered into CARES. The client must present to the ES worker a copy of the Wisconsin Well Woman Program (WWWP) Enrollment Form (DPH 4818) and the Wisconsin MA Determination Form (HCF 10075). Do not require a MA application for these women. Consider the date the Wisconsin MA Determination Form (HCF 10075) is received as the filing date. Use the verification policy stated in the *MA Handbook* 37.0.0 for any items that require verification.

Complete these steps to certify a woman for Wisconsin Well Woman MA:

1. Review DPH 4818 form for these items:

   a. Item #32: *Does the client have any health insurance?*
   b. Item #33: *Does the client have Medicare Part B?*

   Ask the client "*Do you have Medicare Part A?"*

   The answer to all of these questions must be "No" to certify any woman for Wisconsin Well Woman MA.

   If "Yes" is answered to any of these questions, **and** the applicant confirms that her insurance is one of the types noted in #5 of the Policy section, of this memo, the woman is ineligible for Wisconsin Well Woman MA.

2. The client must present a Wisconsin Well Woman Program (WWWP) Enrollment Form (DPH 4818) to the ES worker, who reviews the form for completeness. Check to be sure that the fields 1 – 5, 9 – 13, 16 – 25, 27 – 45, and 48 – 51 are completed on this form. If the form is not complete, request the client to complete any missing information. If the client does not provide this information to ES, there may be a delay of benefits.

3. Check HCF10075 for a Social Security Number (SSN). If a SSN is not present on HCF 10075, check DPH 4818 (#6a). If a SSN is provided, write the SSN in on HCF 10075. If there is no SSN provided on either form, ask the client to provide one or apply for one and record the information on HCF 10075.

   Providing an SSN for the WWWP is voluntary, but for Wisconsin Well Woman MA it is a mandatory item. If a SSN is not listed on either form, the client must provide an SSN, or apply for one to be certified for Wisconsin Well Woman MA.

If the woman fails to provide an SSN or fails to apply for one (*IMM*, Chapter 1, Part C, 8.4.3.1), within the 30-day application processing time or within 10 days, whichever is later, a manual negative notice indicating that the woman is not eligible for Wisconsin Well Woman MA must be sent.

4. Ask the woman if she is a citizen.

   If the woman is not a citizen, ask her to provide her alien registration card, as well as asking about her alien status. Verify that she is in a qualified alien status using the SAVE system (*IMM*, Chapter 1, Section D, 4.0.0).

   Note: Some women with breast and cervical cancer who do not meet the immigration-related eligibility criteria may be eligible to receive emergency services. If a nonqualifying alien has been screened for WWWP, determine her eligibility for emergency services.

5. Manually certify any woman who has met the criteria listed above for twelve months from the filing date and back to whichever is more recent:

   a. Up to 3 months from the filing date, or
   b. To the first of the month in which the date of the diagnosis occurs (HCF 10075), or
   c. Back to January 1, 2002.

   Example: Sherry was diagnosed with cervical cancer on April 16th. The Local WWWP Coordinator had certified her for presumptive eligibility for Wisconsin Well Woman MA from April 16th through May 31st.

   Sherry came in to apply for Wisconsin Well Woman MA on May 5th. ES certifies her for Wisconsin Well Woman MA from April 1st through April of the following year.

   ES sends her a notice indicating that her review is due by the end of April on March 17th.

   Complete a 3070 indicating the beginning and end dates and with a medical status code of "CB". Mail or fax the 3070 to EDS at:

   EDS Eligibility Maintenance
   P.O. Box 7636
   Madison, WI 53707 FAX: 608-221-8815.

6. Send the client a manual positive notice indicating that they are eligible for Wisconsin Well Woman MA if she meets all the criteria listed above. The woman will receive a Forward card and will receive full-benefit MA.

If you are not able to process the application within the 30-day processing time frame, manually submit a 3070 with a medical status code of "CB". Extend her eligibility for an additional 30 days from the last day of her presumptive eligibility for Wisconsin Well Woman MA (noted in the comments section of HCF10075).

Copies of the Wisconsin Well Woman MA Determination form (HCF 10075) will be available to the women at the Local Coordinating Agencies and through WWWP screeners. An example of the form is attached for your information (the attached is only a sample; the actual form may differ slightly in formatting).

If you would like to contact the Local Coordinating Agency, use #27 of the Wisconsin Well Woman Program (WWWP) Enrollment Form (DPH 4818) in coordination with the attached Local Coordinating Agencies list to determine whom to contact.

REVIEWS AND RECERTIFICATION

Reviews/recertifications are required every 12 months after the initial eligibility determination at the client's Wisconsin Well Woman MA enrollment date (see example below). Each local agency must develop a manual method for scheduling and tracking reviews. ES workers must notify the client 45 days before their review is due to schedule a review, and also indicate what materials or information to bring with them or send in. Like other MA subprograms, a client has the choice of handling the review process in person, by mail, or answering any eligibility questions by phone and providing the documentation by mail, fax, or in person to ES.

At review, the woman must provide ES, through the mail or by fax, with a newly completed Wisconsin Well Woman MA Determination Form (HCF10075) indicating that she is still in need of treatment for breast or cervical cancer, as certified by her health care provider.

Terminate eligibility, using adverse action logic, when these women:

1. Reach the age of 65 years
2. Move out of state
3. Report they no longer need treatment for breast or cervical cancer
4. Obtain health insurance or another type of MA

Send a manual negative notice if one of these changes is reported, indicating that the woman is no longer eligible for Wisconsin Well Woman MA.

CONTACT

DWS CARES Information and Problem Resolution Center

Email: carpolcc@dwd.state.wi.us
Phone: 608-261-6317 (Option #1)
Fax: 608-266-8358

Note: Email contacts are preferred. Thank you.

LOCAL COORDINATING AGENCIES

COUNTY / TRIBE	AGENCY	CONTACT		PHONE
Adams	Juneau County Public Health Service	Melanie	Feldman-Gray	608-847-9377
Ashland / Bad River Tribe	Ashland County Health Department	Ann	Schram	715-682-7028
Barron	Barron County Health Department	Nancy	Drake	715-537-6502
Bayfield	Bayfield County Health Department	Elizabeth	Mannik	715-373-6109
Bayfield/Red Cliff Band	Red Cliff Community Health Center	Diane	Erickson	715-779-3707
Brown	Brown County Health Department	Rebecca	Meert	920-448-6438
Buffalo	Buffalo Co Health & Human Services	Holly	Brakke	608-685-6330
Burnett	Burnett County Health Department	Michelle	Bailey	715-349-7600
Calumet	Calumet County Health Department	Jennifer	Colla	920-849-1432
Chippewa	Chippewa County Department of Public Health	Jean	Durch	715-726-7900
Clark	Clark County Health Department	Carrie	Wiersma	715-743-5114
Columbia	Divine Savior Healthcare	Debbie	Bruning	608-745-6407
Crawford	Crawford County Public Health	Mary	Mathison	608-326-0229
Dane	Dane Co Dept of Human Serv-Public Health Div	Kari	Sievert	608-242-6392
Dodge	Dodge County Human Services & Health Dept	Joann	Kernan	920-386-3670
Door	Door County Public Health Nursing Service	Beth	Krohn	920-746-9704
Douglas	Douglas County Health Department	Audrey	Pederson	715-395-1617
Dunn	Dunn County Health Department	Dianne	Robertson	715-232-2388
Eau Claire	Eau Claire City-County Health Department	Joyce	Wachsmuth	715-839-4718
Florence	Florence County Health Department	Karen	Wertanen	715-528-4837
Fond du Lac	Fond Du Lac County Health Dept (CWCP)	Cecelia	Grimmer	920-926-4116
Forest	Forest County Health Department	Debbie	Bellamy	715-478-3372
Forest Potawatomi Tribe	Forest County Potawatomi	Kathy	Chitko	715-478-7367
Grant	Grant Co. (Southwest Community Action Program, Inc.)	Penny	Clary	608-935-2810
Green	Green County Health Department	Dawn	Knaus	608-328-9390
Green Lake	Green Lake County Human Serv Dept-Health Unit	Deb	Washkoviak	920-294-4070
Ho Chunk Nation	Ho Chunk Health Dept	Linda	Severson	715-284-7548
Iowa	Iowa Co. (Southwest Community Action Program, Inc.)	Penny	Clary	608-935-2810
Iron	Iron County Health Department	Julann	Ritter	715-561-2191
Jackson	Jackson County Public Health	Tammy	Danielson	715-284-4301
Jefferson	Jefferson County Health Department	Sandee	Schunk	920-674-7193
Juneau	Juneau County Public Health Service	Melanie	Feldman-Gray	608-847-9377
Kenosha	Kenosha County Division of Health	Pam	Kavalauskas	262-605-6757
Kewaunee	Kewaunee County Public Health Department	Cindy	Kinnard	920-388-7160
Lac Courte Oreilles Tribe	Lac Courte Oreilles Community Health Center	Sandy	Bird	715-634-4795
Lac du Flambeau Tribe	Peter Christensen Health Center	Kelli	Stanczak	715-588-3371
LaCrosse	LaCrosse County Health Dept	Sarah	Peterson	608-785-9723
Lafayette	LaFayette Co. (Southwest Community Action Program, Inc.)	Penny	Clary	608-935-2810
Langlade	Langlade County Health Department	Connie	Alft	715-627-6250
Lincoln	Family Planning Health Services, Inc.	Chris	Hanke	800-246-5743
Manitowoc	Manitowoc County Health Department	Joyce	Kleppe	920-683-2750

COUNTY / TRIBE	AGENCY	CONTACT		PHONE
Marathon	Family Planning Health Services, Inc.	Chris	Hanke	800-246-5743
Marinette	Marinette County Public Health Department	Susan	Nelson	715-732-7677
Marquette	Green Lake County Human Serv Dept-Health Unit	Deb	Washkoviak	920-294-4070
Memoninee	Menominee Tribal Clinic	Charmaine	Merrit	715-799-5437
Milwaukee (City of)	City of Milwaukee Health Department	Mildred	Leigh-Gold	414-286-2133
Milwaukee (excl City Mke)	West Allis Memorial Hospital	Nancy	Rhodes	414-328-7407
Monroe	Monroe County Health Department	Linda	Smith	608-269-8666
Oconto	Oconto Co Dept of Human Serv Public Health Division	Sara	Applebee	920-834-7064
Oneida	Oneida County Health Department	Diana	Kunda	715-369-6108
Oneida Tribe	Oneida Community Health Center	Tara	Anderson	920-869-2711
Outagamie	Planned Parenthood of Wisconsin, Inc.	Megan	Heck	920-731-7142
Ozaukee	Ozaukee County Public Health Department	Donna	Ubbink	262-284-8170
Pepin	Pepin County Health Department	Jo Ann	Rucker	715-672-5961
Pierce	Pierce County Public Health Services	Colleen	Clark	715-425-8003
Polk	Polk County Health Department	Lori	Wicklund	715-485-8500
Portage	Family Planning Health Services, Inc.	Chris	Hanke	800-246-5743
Price	Price County Health Department	Lynn	Downing	715-339-3054
Racine	Racine City Health Department	Pat	Holly	262-636-9292
Richland	Richland County WWCCP Coordinator	Penny	Clary	608-935-2810
Rock	First Choice Women's Health Center	Michelle	Leverence	608-755-2438
Rusk	Rusk County Health Department	Brenda	Cigan	715-532-2299
Sauk	Juneau County Public Health Service	Melanie	Feldman-Gray	608-847-9377
Sawyer	Sawyer County Health Department	Jeanine	Connell	715-634-4874
Shawano	Shawano County Health Department	Jessica	Wiesman	715-526-4808
Sheboygan	Planned Parenthood of Wisconsin, Inc.	Sandy	O'Neill	920-731-7142
Sokaogon Chippewa Tribe	Sokaogon Chippewa Health Clinic	Judy	Anaya	715-478-5180
St. Croix	St. Croix Co Dept of H&HS/Pub Hlth	Jaye Ann	Hay	715-246-8263
St. Croix Tribe	St. Croix Tribal Health Department	Ardys	Noreen	715-349-8554
Stockbridge-Munsee Tribe	Stockbridge-Munsee Comprehensive Health Center	Doreen	Martin	715-793-4144
Taylor	Taylor County Health Department	Brenda	Herrell	715-748-1410
Trempealeau	Trempealeau County Health Department	Cheryl	Rhoda	715-538-2311
Vernon	Vernon County Public Health Department	Emily	Olson	608-637-5251
Vilas	Vilas County Public Health Department	Pamela	Pedersen	715-479-3757
Walworth	Walworth County Human Service Department	Kay	Meyer	262-741-3140
Washburn	Washburn County Public Health/Home Care	Jerri	Pederson	715-635-7616
Washington	Washington County Health Department	Linda	Benedict	262-335-4472
Waukesha	YWCA of Waukesha	Marlys	Swanson	262-547-1872
Waupaca	Waupaca Co Dept of Human Serv-Health Serv Div	Janet	Resop Reilly	715-258-6390
Waushara	Green Lake County Human Serv Dept-Health Unit	Deb	Washkoviak	920-294-4070
Winnebago	Planned Parenthood of Wisconsin, Inc.	Megan	Heck	920-731-7142
Wood	Wood County Health Department	Dawn	Roznowski	715-421-8911

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF10075 (01/02)

STATE OF WISCONSIN
Wis. Stats. 49.473

WISCONSIN WELL WOMAN MEDICAID DETERMINATION

Instructions:
Part A – **Applicant Information** - This section needs to be completed by the applicant. Completion of this form is required to enable the Medicaid Program to authorize and pay for medical services provided to eligible recipients. Under 49.45 (4) WI Statutes, personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to the Medicaid program administration such as determining eligibility of the applicant. Failure to supply the information requested by this form may result in denial of Medicaid payment for the services.

- Enter applicant's name as it appears on the Wisconsin Well Woman Program Enrollment form (DPH 4818). Attach a copy of DPH 4818 to this form.
- Enter applicant's address (must be a Wisconsin address).
- Enter applicant's social security number (SSN). The provision of the SSN is required under Wisconsin Administrative code HFS 103.03 (4) for any person requesting medical services covered by the Medicaid program. The SSN will only be used to determine eligibility for Medicaid. If the SSN is not provided benefits may be denied.
- Enter applicant's date of birth. Applicant must be 35 through 64 years of age.
- Applicant must sign and date the form.

Part B – **Referring Health Care Screener/Provider** - This section of the form is to be filled out by the Wisconsin Well Woman Program screener/health care provider.

- Enter the name of the health care provider who is attesting to the screening, diagnosis and treatment recommendation.
- Enter the date the screen was done.
- Enter the date of diagnosis. This date should be on or after the date of the screen.
- Enter the diagnosis. It may be any diagnosis of a condition of breast or cervical cancer or pre-cancerous lesions requiring treatment.
- The treatment recommended box must be checked "yes".
- The screener/health care provider must sign, indicating medical credential, and date the form.

Part C - Economic Support (ES) Worker can add comments as needed.

PART A - Applicant Information

Name – Last	First	MI	Social Security Number

Street Address	City	State	Zip	Birthdate (mm/dd/yy)

SIGNATURE – Applicant	Date Signed (mm/dd/yy)

PART B - Referring Health Care Screener / Provider

Name - Last	First	MI

Screener / Provider Street Address	City	State	Zip

Date of Screen	Date of Diagnosis	Treatment Recommended? ☐ Yes ☐ No

Diagnosis

SIGNATURE – Referring Health Care Screener / Provider	Date Signed (mm/dd/yy)

PART C - Comments

Agency	ES Worker Use Only	Office

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health
DPH 4818 (Rev. 11/00)

STATE OF WISCONSIN
s. 255.075, Wis Stats.

WISCONSIN WELL WOMAN PROGRAM (WWWP) ENROLLMENT

Read instructions on reverse prior to completing this form. Print clearly. Client information in this document is confidential under Wis. Stats 146.82

PERSONAL INFORMATION – Completed by Client

1. Last Name _____ 2. First Name _____ 3. Middle Name _____

4. Maiden Name _____ 5. Date of Birth (mm/dd/yyyy) _____ 6a. Social Security No. (Optional) _____ - _____ - _____

6b. Client Identification No. (Assigned by Local Coordinating Agency) _____ - _____ - _____

7. Race ☐ Aleutian ☐ American Indian ☐ Asian ☐ Black ☐ Eskimo ☐ Hmong ☐ Other ☐ Pacific Islander ☐ Unknown ☐ White

8. Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

9. Street Address _____ 10. City _____ 11. State _____ 12. Zip _____

13. County _____ 14. Day Telephone No. (_____) _____ 15. Night Telephone No. (_____) _____

16. Mailing Address _____ 17. City _____ 18. State _____ 19. Zip _____

20. Name of contact person, not living with you _____ 21. Relationship _____

22. Address _____ 23. City _____ 24. State _____ 25. Zip _____

26. Contact Person's DayTelephone No. (_____) _____ Night Telephone No. (_____) _____

ENROLLMENT INFORMATION – Completed by Enrollment Site

27. Enrollment Site Name _____ 28. Site City _____

29. Site County / Tribe _____ 30. Enrollment Date (mm/dd/yyyy) _____

31. Enrollment Site Number (if known) _____

INSURANCE INFORMATION – Completed by Client

32. Do you have any health insurance? ☐ Yes ☐ No 33. Do you have Medicare Part B? ☐ Yes ☐ No

HEALTH CARE PROVIDER INFORMATION – Completed by Client

34. Do you have a primary health care provider? ☐ Yes ☐ No 35. If Yes, Name of Provider _____

36. Street Address _____ 37. City _____ 38. State _____ 39. Zip _____

40. Do you have a primary care clinic? ☐ Yes ☐ No 41. If Yes, Name of Clinic _____

42. Street Address _____ 43. City _____ 44. State _____ 45. Zip _____

46. How did you hear about this program? ☐ WWWP Coordinator ☐ Relative / Friend ☐ Radio / TV ☐ Newspaper ☐ Brochure / Poster
☐ Clinic / Health Care Provider ☐ Other _____

47. CLIENT PARTICIPATION AGREEMENT

I understand and agree to the following; the Wisconsin Well Woman Program (WWWP) will use the personally identifiable information only for program enrollment and case management. I give WWWP permission to release my medical information to the Local Coordinating Agency (LCA), other service providers, referral agencies and the State of Wisconsin. I understand that WWWP pays for preventive screening services, but does not pay for medical treatment services. I have seen the current program eligibility criteria and, to the best of my knowledge, my annual income does not exceed them. All of the information I have given is true and correct. I will inform the WWWP LCA if I move or if I no longer wish to participate. I understand the enrollment is valid for one (1) year from the date signed.

48. **SIGNATURE – Applicant** 49. **Date Signed**

50. **SIGNATURE – Witness** 51. **Date Signed**

Office Use Only

☐ New Enrollment ☐ Meets Eligibility Requirements ☐ Age_____ ☐ Income $_____ ☐ Household size____ ☐ Uninsured ☐ Underinsured

☐ Re-Enrollment ☐ Meets Eligibility Requirements ☐ Age_____ ☐ Income $_____ ☐ Household size____ ☐ Uninsured ☐ Underinsured

☐ Inactive ☐ Out or Area ☐ Deceased Date_____(mm/dd/yyyy)

☐ Refer for CBE and / or Mammogram Provider Name _____

☐ Refer for Pelvic and PAP Provider Name _____

☐ Refer for other Well Woman Screening Provider Name _____

Name of Interviewer _____

Return completed,white copy only, of form to: WWWP – Fiscal Agent, P. O. Box 6645, Madison, WI 53716-0645

White (Top) Copy– Fiscal Agent Yellow (2nd) Copy – Provider Pink (3rd) Copy – Local Coordinating Agency Blue (4th) Copy – Client

WISCONSIN WELL WOMAN PROGRAM (WWWP) ENROLLMENT INSTRUCTIONS

Completion of this form is required to determine your eligibility for services with WWWP. The Department of Health and Family Services has the authority to collect personally identifiable information necessary to determine eligibility for services for the WWWP. The personally identifiable information collected on this form will ONLY be used to determine eligibility for services and case management. Provision of the Social Security Number is optional.

PERSONAL INFORMATION

1. Print your last name.
2. Print your first name.
3. Print your full middle name.
4. Print your maiden name, if applicable.
5. Indicate date of birth. Use numbers for month, day and year, i.e. 01/15/1935.
6. Indicate your Social Security Number.

   6a. Your Social Security Number is optional and will be used to determine your eligibility for services and to identify your status with other health care programs.

   6b. If Client Identification Number is used instead of the Social Security Number, the Local Coordinating Agency should assign this number.
7. Indicate your race by checking the appropriate box. This information will be used for statistical purposes only.
8. Indicate your ethnicity by checking the appropriate box. This information will be used for statistical purposes only.
9. Indicate number and street address of your residence; include apartment number if applicable.
10. Indicate your city of residence.
11. Indicate your state of residence.
12. Indicate your residential zip code.
13. Indicate your county of residence.
14. Indicate your daytime telephone number, with area code. If there is no phone, indicate "none".
15. Indicate your night / evening telephone number, with area code. If there is no phone, indicate "none".
16. Indicate your mailing address, if different from your residential street address.
17. Indicate the city of your mailing address, if different from your residential address.
18. Indicate the state of your mailing address, if different from your residential address.
19. Indicate the zip code of your mailing address, if different from your residential address.
20. Indicate the name of a contact person, not living with you. This person should have a telephone.
21. Indicate the relationship of the contact person to you, i.e. husband, mother, son, neighbor, etc.
22. Indicate the contact person's address.
23. Indicate the city for the contact person's address.
24. Indicate the state for the contact person's address.
25. Indicate the zip code for the contact person's address.
26. Indicate the contact person's day or evening telephone number, with area code. If there is no phone, indicate "none".

ENROLLMENT INFORMATION

27. Indicate the client's enrollment site name. (example: Wisconsin County Medical Center)
28. Indicate the city of the enrollment site.
29. Indicate the county or tribe of the enrollment site.
30. Indicate the enrollment date. Use numbers for month, day and year, i.e. 01/15/2001.
31. Indicate the enrollment site number (if known).

INSURANCE INFORMATION

32. Check "Yes" if you currently have private, group or other Health Insurance coverage as well as any other type of coverage. Check "No" if you do not.
33. Check "Yes" if you receive Medicare Part B. Check "No" if you do not.

HEALTH CARE PROVIDER INFORMATION

34. Check "Yes" if you have a primary health care provider (physician). Check "No" if you do not.
35. Indicate the name of your primary health care provider.
36. Indicate the street address for your primary health care provider.
37. Indicate the city where your primary health care provider is located.
38. Indicate the state where your primary health care provider is located.
39. Indicate the zip code for your primary health care provider.
40. Check "Yes" if you have a primary care clinic. Check "No" if you do not.
41. Indicate the name of your primary care clinic.
42. Indicate the street address of your primary care clinic.
43. Indicate the city where your primary care clinic is located.
44. Indicate the state where your primary care clinic is located.
45. Indicate the zip code where your primary care code is located.
46. Please indicate how you heard about the Wisconsin Well Woman Program by checking the appropriate box.

CLIENT PARTICIPATION AGREEMENT

47. Read the agreement carefully. If you have any questions regarding completion of this form, contact your Local Coordinating Agency.
48. Sign the agreement using your legal signature.
49. Indicate the date on which you sign this form.
50. The witness signature will verify that the client signed this form.
51. The witness will indicate the date that he / she signed this form.

Return completed form, White (Top) Copy Only to:

WWWP
P. O. BOX 6645
MADISON, WI 53716-0645